North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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MEMORANDUM

TO: North Carolina Association of County Commissioners
North Carolina Council of Community Programs
Area Program Directors
Area Program Board Chairs
County Managers
County Commission Chairs
Legislative Oversight Committee Members
MH/DD/SAS Commission Chair
Consumer/Family Advisory Committee Chairs
Advocacy Organizations and Groups
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

FROM: Richard J. Visingardi, Ph.D.

RE: **COMMUNICATION BULLETIN # 005**
Questions and Answers for County Commissioners/Managers

The purpose of this memo is to respond to questions posed by county commissioners and managers regarding state mental health reform. I hope this information is helpful to all of you as we move forward together in this process.

Q 1. What are the actual responsibilities of the county commissioners in reference to the new state plan for mental health? In drawing up the local business plan?

A That depends on the local decisions. The county commissioners eventually have to approve

the plan; however they may decide to be a part of the actual writing of the plan or any variation. The methods by which the counties are participating in the development of the plan vary across the state. There are 3 basic responsibilities:

1. They have to decide on the governance option.
2. They have to approve the plan.
3. They have to monitor the implementation of the plan.

Q 2. Do the County Commissioners have to pass the LME's business plan?

A Yes, G.S.122C-115.2 (a) states, "every county, through an area authority or county program shall provide for development, review and approval of a business plan…" In addition, G.S.122C-115.2(c) states, "business plan shall submit the proposed plan as approved by the board of county commissioners to the Secretary…"

Q 3. What happens if mental health board passes the plan but the county does not?

A The plan may not be submitted without approval of the county commissioners even if the governance is an area authority model.

The intent of the local business plan is to have all the appropriate stakeholders, agencies, providers, families and consumers involved with the development of the plan. These issues should be known and negotiations taking place at the beginning of and throughout the process. It is hoped that by the time any board or the local CFAC (Consumer/Family Advisory Committee) reviews the plan there would be no surprises.

If for some reason, the process doesn't work, even after Department mediation, then the ultimate decision falls under the Secretary's authority to assume control of the county or area authority program. The conditions of and process are outlined in G.S.122C-115.3

Q 4. What oversight do the county commissioners have? Specifically what, how often and how detailed should the information be that the county commissioners receive in order to assure accuracy and accountability on the part of the LME and the mental health board?

A This area was changed dramatically with the reform legislation, and this question was one of the major reasons for reform; commissioners expressed concern regarding their knowledge and involvement with the area authorities. Some of the specifics are determined by the governance model, but for all models the following apply (G.S. 122C-115.2, 122C-117, 122C-118.2) and became effective July 1, 2002.

1. Receive findings and recommendations based upon the Secretary's regularly scheduled monitoring and oversight of area authority, county programs. Monitoring and oversight shall include compliance with the program business plan, core administrative functions and fiscal and administrative practices and shall also address outcome measures such as consumer satisfaction, client rights complaints and adherence to best practices.

2. The development and approval of the business plan is also an oversight tool. The plan shall

provide detailed information of how the area program or county model will meet state standards, laws and rules for ensuring quality mh/dd/sa services, including outcome measures for evaluating program effectiveness.

3. All approvals, corrections or modifications of the local plan as requested by the Secretary must be copied to the county commissioners.

4. Amendments to the local business plan shall be subject to the approval of the participating boards of county commissioners.

5. Receive approved budgets and quarterly reports on the financial status of the program.

6. The county commissioners, unless waived, shall approve the appointment of the area director. The search committee shall have one or more county commissioners among the other members.

7. Receive recommendations for the creation of local program services.

8. Receive quarterly service delivery reports that assess the quality and availability of public services within the catchment area. Reports shall include types of services delivered, number of recipients served, services requested but not delivered due to staffing, financial or other constraints.

9. Receive at least annually a progress report that includes assessment of the progress in implementing local plan, goals and outcomes.

10. All reports shall be in a format and shall contain any additional information required by the Secretary or board of county commissioners.

11. Within 30 days of the end of each quarter of the fiscal year, the area director and finance officer shall provide to each member of the board of county commissioners the quarterly report of the area authority in a format prescribed by the county. At least twice a year, the information shall be presented in person.

12. Receive additional ad hoc reports as requested by the county.

13. Multi-county area authorities shall provide to each board of commissioners a copy of the annual audit. The audit findings shall be presented in format prescribed by the county and shall be read into the minutes of the meeting at which the audit findings are presented.

14. Appointment of the area board members within the applicable categories.

15. Area directors must have annual evaluations using criteria established by the Secretary. The area board must consider the comments from county commissioners.

Q 5. **What requirements are there as to the composition of the new mental health board in reference to certain professionals, customers, family members etc? How should these people be chosen or spread out among multiple counties?**

A G.S. 122C-118.1 outlines the structure requirements of the area board. Highlights of the

section include:

1. No fewer than 11 and no more than 25 members.

2. In single county area programs, county commissioners appoint members.

3. In multiple counties, each board of county commissioners within the area shall appoint one commissioner as member of the board. These members shall appoint the other members.

4. The boards of county commissioners within the multi-county area shall have the option to appoint the members of the area board in a different manner by adopting a resolution. The method shall be outlined in the local business plan.

5. At least 50% shall represent a physician, clinical professional from mh/dd/sa, family member or consumer of mh/dd/sa and openly declared consumer of mh/dd/sa.

Q 6. Do County Commissioners have any liability with respect to controlling costs? Do Commissioners need to review the budgets in detail?

A As referenced in G.S. 122C –117 (4), area programs/county programs must submit budgets, and county commissioner board(s) must receive the budget and receive reports regarding the financial status of the area authority or county program as outlined in 122C-117(c). Details of the report (ing) are at the discretion of the local county commissioners. In multi-county programs, this area should be presented as part of the local business plan as negotiated with the county commissioners.

The Division of MH/DD/SAS has requested an overall interpretation from the attorney general's office regarding liability issues for the county commissioners for area authority models and county models.

Q 7. How do we control spending if services are contracted out? How will we control transportation expenses?

A A cost of service provision is part of the contracting requirements as outlined by the state and LME and the rate setting procedures outlined by the state. Bundling of services and network development are part of the decision points in selecting providers and in local business plan development. Each community must evaluate those factors as part of their provider network.

Transportation is an essential component of service delivery and its availability, access and costs must be considered in the development of the community services and support system for which the LME is responsible. Transportation costs may be included in the provider network as part of a more comprehensive service/support framework.. Transportation should also be viewed as a community issue and not just a mh/dd/sa service. The LME, in its role as public policy manager must work with all of its community partners to develop community transportation for consumers and families. This is true especially in rural areas. The use of vouchers is also an allowable option. Any transportation needs for each consumer should be as part of his or her person centered plan.

Contracting for services does not equate with unlimited billing. The LME/state and/or the utilization management contractor still will be responsible for authorization of services, units and/or rates.

Q 8. How are other LMEs across the state addressing the issue of funding? Specifically, what functions and line items are considered administrative and fall within the 13% allowed administrative budget? Where is the oversight for this?

A The reform bill required that a standardized cost finding format be developed to capture administrative costs. This work was completed and cost-finding procedures modified. This process is only relevant for the existing fiscal year. The appropriations bill allows for a different methodology to be developed to capture the cost as the LME model is put in place. The standardized format is located at the following web address:
HYPERLINK http://www.dhhs.state.nc.us/controll/amh/amhauth.htm
www.dhhs.state.nc.us/control/amh/amhauth.htm

A work group facilitated by an outside contractor has developed a cost modeling formula for LMEs. This process is in the final stages. Preliminary recommendations have been made and final recommendations will be submitted for discussion to the Departmental finance committee.

This finance committee is comprised of representatives from the Secretary's office, Division of Medical Assistance, controller's office, office of budget and planning, and Division of MH/DD/SAS. Other departments, divisions and stakeholders will be brought in periodically. The Division will keep the NC Council of Community Programs and the NC Association of County Commissioners involved in the process at all points.

For FY 02-03, administrative costs remain limited to 13% and are subject to audit and settlement as prepared by the controller's office.

Q 9. If the LME is supposed to perform the core functions (screening, assessment, referral emergency triage and care services, and care coordination, education and universal prevention) for all populations, not just target populations, what funds will be used to do this? Does all of the Medicaid money have to go the client's actual service provider?

A In future years, core functions will be funded in a different manner than the area authority is currently funded. This is part of the cost modeling process. Ranges for costs for LME functions have been outlined. The Department finance group is addressing this area as well. Medicaid rates are paid to the provider except for the allowable administration. In the future LMEs will be paid off the top and not as funds withheld from Medicaid rates. Medicaid funding may be used to help offset the overall costs but will be billed through administrative Medicaid funding and not based on Medicaid direct service dollars.

Q 10. Is there a specific model to follow for the needs assessment?

A The state has not mandated a model for the local business plan needs assessment other than one that identifies strengths, weaknesses, opportunities and threats.

The state is required to identify the elements of clinical needs assessments for the treatment and support of a person with a disability in order to insure consistency across the area programs/county programs. Although the phase in programs may be allowed to pilot varying types of clinical needs assessments, the process and elements must eventually go through the Commission of MH/DD/SAS for rulemaking and statewide implementation.

Q 11. How will the payback issue work under the new system?

A That depends on whether direct enrollment to Medicaid for Medicaid paybacks are allowed. The federal requirements looks to the enrolled provider as the entity responsible for the payback. The entity, if contracting, can include paybacks as the responsibility of the contractor, but the official agency is the enrolled provider. For state dollars and other federal dollars, the LME will assume responsibility.

Q 12. Specifically, where does the state expect the savings to occur? Will those savings be used toward mental health client services?

A There is the expectation that over time consolidation efforts of administrative functions along with the use of more community based services and movement to supports and best practices/emerging best practices will result in savings. The Secretary along with other state officials are committed to keeping the dollars saved in administration costs for the provision of mh/dd/sa services.

The reform bill requires that the local business plan identify how “proposed reinvestment of savings toward direct services” will occur. It may be several years before such savings are realized. Consolidations, mergers and acquisitions typically require more costs up front with the realization that savings occur over time.

The state also expects there to be savings in moving consumers to community based services from the state operated institutions/hospitals. While a small percentage of consumers will continue to require intensive, high cost, facility-based services, it is expected that the existing costs of state operated services in hospitals and institutions will be spread further across less costly community based services as they are developed.

Q 13. Where do all the current clinicians who are county or authority employees go? What if there are no private providers for them to join? What is supposed to happen to their retirement accounts, insurance, sick and vacation leave?

A These are difficult decisions that every staff member must address. The individual may find that depending on age, etc the transfer out of the public system to the private system is more profitable, including transferring retirement to plans other than state retirement. This

factor collectively needs to be weighed in looking at transitioning of the area program system. Area authorities/county programs should review this collective information as part of the overall transition.

Many area authority staff have used the opportunity to open up businesses of their own utilizing the area authority/county model for their administrative support. Area authorities have developed private, non-profit organizations as service providers. Some areas have placed employees within other areas of county government as a means of addressing the required multiple points of access or the sharing of revenue to address fragmentation of services. The Division of MH/DD/SAS has explored legislative action that might serve to protect employees' retirement benefits. To this date, no legislative action has proven viable.

Q 14. Specifically, who will have the responsibility of credentialing licensed providers? Will the state protocol for this be the same? Will this credentialing have to be completed before the client services are rendered? What kind of reporting will be required to assure accountability and who will oversee this area?

A The state plan requires both a state and local monitoring process. Licensure requirements will be established by the Commission of MH/DD/SAS, and licensure will be carried out between the Division of Facility Services (DFS) and the providers, with inspections as outlined by the Department. The state is committed to the local LME being the eyes and ears of the local community regarding ongoing monitoring of the quality of the providers. The recently ratified Senate Bill 163, Section 4.2 demonstrates the commitment for area programs/county programs to have the authority to provide local monitoring. This is part of the reason for the separation of the services and management. The process by which the providers are monitored by the LME will be standardized. The LME cost modeling captures the costs associated with local monitoring of providers. This area will be further addressed in the next legislative session. The state is committed to working with the Legislative Oversight Committee regarding statutory changes that clearly grant the LME authority to conduct the monitoring and provide the necessary follow-up.

Q 15. How do you assure there is consumer choice?

A Consumer choice is at various levels throughout the assessment and treatment process. It is also dependent on local issues regarding access points and network development. Consumers should have choice about treatment and support options, and services. In many cases, choice of providers will also be available but that will depend on the scope of the provider network and the bundling of services and supports to adequately fund the range of services and supports required. Even if the actual number of providers is limited, individual clinicians or case managers should be available. Having choices includes the ability to request a different case manager when employed by the same agency, even if this is the LME.

There will be some areas in which families and consumers must comply with certain requirements if they want to receive services from the public system. Examples of this include supplying information required for the LME to pursue billing through the Integrated Payment and Reporting System (IPRS) and assessment/screening requirements.

Choice is not granted for the continuation of services that have not produced meaningful outcomes for people. Choice will be provided, when possible, to support best practice and emerging best practices.

Q 16. Will there be state protocol established as to the acceptable time lapse between client access, screening, assessment, referral and treatment and reporting related information?

A Yes, this is the intent of establishing a system that is measured based upon outcomes. However, this process must flow with the overall development and implementation of LME roles, financing of services and establishment of the technology to gather the information.

Several of the phase one programs have requested to pilot some outcome measures as well as methods of collecting the data. In addition, a work group has been developing access standards which are those areas referenced above. Reporting requirements will be minimally established by the state but also can be required as part of the report to the County Commissioners.

Q 17. Will there be a state protocol as to how far a client can travel to receive services?

A One of the standards listed in the local business plan requirements is 30 minutes/30 miles, with the local consumer/family advisory committee (CFAC) being given a role in developing the parameters based upon local factors around which exceptions would be granted to this requirement. Such factors may include geographic barriers or local funding. The reason for the exception must be defended and proven.

There is no expectation that the consolidation of management functions will have negative impact in the actual delivery of direct services. The local community still should have

capacity to meet the access standards. That is why the plan also calls for movement to best practices or emerging best practices along with service delivery occurring in the most natural environments or in areas that are frequently visited or used by target populations. This includes home based services, services located in schools, health departments, etc. Requiring consumers and their families to come to the mental health center may actually be seen as a barrier to access.

Q 18. Is there a change on the part of the state in reference to the definition of the disease process for certain diagnoses and in what setting is the best treatment? Who will oversee this?

A The LME is responsible for the overall management of mh/dd/sa services provided in the local community. The state will establish guidelines and protocols for best practice implementation. The state will limit the payment of services to those areas that are known to be effective for diagnosis or are known to produce results for people. In addition, the LME is responsible for addressing the issues as part of the local business plan development.

Q 19. How should the local consumer/family advisory committee be formed or established? Equal representation from each county for each client group? How will it be funded?

A The CFAC is factored into the overall cost modeling for the LME. How it is developed will differ among communities. Some communities have a CFAC in each county, with representatives of those committees feeding in to a larger overall CFAC. Other communities are pursuing a CFAC that will serve as the advisory board to a county commissioner board (in a county model). How the committee is established should be driven by community decision making. The state's intent is that each committee be made up of families and consumers representing the various disability areas that speak on behalf of families and consumers within the area.

Q 20. Will clients continue to receive quality care?

A The end result of reform is to improve the quality of care to consumers and their families. The state plan requires better lines of accountability between the state, local communities, families and consumers and providers. Publications of reports, report cards and the overall infrastructure of the quality improvement process refocuses the definition of quality to a system that provides meaningful outcomes to consumers and families and that is not strictly based upon compliance. There are programs and providers who meet every compliance standard but don't provide the best practice for target populations or even utilize the standards of care recognized to provide meaningful outcomes.

Q 21. Should every county have a site manager?

A Not necessarily. The decision about site managers should be directly related to the access points and how the local system is developed as outlined in the local business plan. For example, if the access points are located in other public agencies or existing provider sites, site managers may not be needed. Replication of administrators for the sake of having a presence is not necessary if other management means can accomplish the desired

outcomes and oversight responsibilities. This is an area that savings can be realized.

Q 22. What if the LME has no local employees - all the employees are in another county?

A Although the state recognizes the need to support the local community, the staffing of the LME should be developed in a manner that produces the most efficient use of financial resources. This may include contracting with agencies or suppliers that are not in the local community. This is especially true in the areas where technology plays a vital role.

The local employee presence should be also reviewed in terms of response time and availability as requested and required in the local business plan and by the county commissioners. The residence of staff has been a legal issue and any such requirement and discussion should involve legal counsel. Consideration will also need to be given to the number of consumers and frequency of services for the LME functions and target population locations.

It is anticipated that this will become an issue of lesser concern as LMEs transition to their new role as public policy managers and oversee rather than deliver the services and supports directly. Citizens, including consumers and families, are primarily concerned that services and supports are available and accessible as close to home as possible. If the service/supports array meets the community need, where management staff resides is not an issue.

Q 23. Can any area program or county model request a Division liaison?

A Yes, Phase I area programs have been assigned Division liaisons or technical assistance staff. As other area programs or county programs make the request, Division staff are being assigned.

Q 24. How does the county decide what services it will provide? Are there still mandated services?

A The current list of mandated services as printed in the APSM 45-1 does not reflect best practices. The rules committee, a committee of the Commission for MH/DD/SAS will address the need for revisions and modifications of most current rules. The Commission and the Secretary are required to establish rules, modify rules and coordinate among the various commission rules and policies to implement the reform. An example of this is in the area of ACT (Assertive Community Treatment) teams. The research clearly indicates this to be an effective service for people with mental illness; however this service is currently not a mandated service.

Several LMEs have requested waivers in order to move forward with innovative and creative ideas as developed through their local business plans. These will be used to pilot ideas before statewide implementation. This also addresses the overall need for consistency among communities but also the ability to change the process for actual implementation in order to meet the needs of the local community.

Thank you.

RJV/jk

cc: Secretary Carmen Hooker-Odom
Deputy Secretary Lanier Cansler
Assistant Secretary of Health James Bernstein
DMH/DD/SAS Staff